i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET				
		155697	B. WIN			02/24/	2012
NAME OF B	DOLUBER OR GURRY IER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			517 N L	ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	This visit was for State Licensure Sincluded the Investigation Investigation (Included Investigation) (Investigation) (Inv	r a Recertification and Survey. This visit estigation of Complaint 103217 - Unsubstantiated idence ebruary 21, 22, 23, 24, 1000059 11: 155697 100266560 RN TC N RN ISW	F00	TAG	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation on or after March 25 2012.	of t s	DATE
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURI	3	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

000059

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/24/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD (SVILLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Sample: 15 Supplemental Sample: 3			
	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.			
	Quality review 2/29/12 by Suzanne Williams, RN			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 2 of 43

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155697	A. BUILDING 00 COMI		(X3) DATE SURVEY COMPLETED 02/24/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on observation, record review and	F0157		03/25/2012
	interview, the facility failed to notify the physician of medication not provided as		What	
	ordered for 1 of 2 residents reviewed for physician notification in a supplemental		corrective	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 3 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVE	EY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			,	
		155697	B. WIN	_		02/24/2012	
NAME OF I	PROVIDER OR SUPPLIE	3			ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	R		LITTLE LEAGUE BLVD (SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	IPLETION DATE
TAG	sample of 3. (Re	· · · · · · · · · · · · · · · · · · ·		TAG			DATE
	sample of 3. (Re	esident #70)			action(s) will		
	Findings:				be		
	On 2/23/12 at 10:45 a.m., Resident #70's				accomplished		
	physician was seated at the Nurse's Desk				for those		
	and was visibly upset an order for						
medication had not been started. The					residents		
	nurse standing at the desk indicated it would be taken care of right away.				found to have		
					been affected		
	The clinical record for Resident #70 was reviewed on 2/23/12 at 9:20 a.m. The				by the		
		oses included, but were			Deficient practice:		
	1	ementia, diabetes type II			Resident #70's antibiotic w	as	
		infection. On 2/22/12 at			started.		
		sician ordered Macrobid				_	
		y tract infection) 500 mg			How will you ident	ify	
		O (two times a day) for 7			other residents		
	days.	3,			Having the potential to be		
					affected by the same deficien practice and what corrective	t	
	On 2/23/12 at 11	:37 a.m., in interview			action will be taken:		
	with LPN (Licer	nsed Practical Nurse) #2,			· All residents have the pote	ntial	
	he indicated he v	worked second shift and			to be affected by the alleged		
	was unable to ge	et the order clarified. He			deficient practice. The licensed nurses will be		
	passed the conce	ern onto the next shift			re-educated 3/13/12 by the		
	nurse. He heard	the ordered medication			DNS/designee on timely		
		rted. Staff failed to notify			notification of physician. Post included.	test	
	the physician aft	-			All physician orders are		
	_	rdered medication for a			reviewed daily by the		
	clarification of the	he order.			DNS/designee with follow-up		
					using the daily minutes tool to ensure physician orders are in		
		40 p.m., in interview with			place and being followed.	'	
	I the Corporate Re	egistered Nurse, she			1.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		155697	B. WING 02/24/2012			02/24/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	₹		517 N L	ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	·	DATE
	-	acy questioned the dose			What measures will be put into place or what systemic change	
	as there were no 500 mg tablets, only 50 and 100.				you will make to ensure the	
					deficient practice does not rec	ur:
					The licensed nurses will be	
	On 2/24/12 at 1 p.m., review of the policy and procedure for Resident Change of				re-educated 3/13/12 by the	
					DNS/designee on timely notification of physician.	
	Condition, dated	revised 3/10, included,			The director of nursing	
	but was not limited to: "It is the policy of				services/designee is responsib	ole
	this facility that all changes in resident condition will be communicated to the physician and family/responsible party,				to ensure compliance.	
					· All physician orders are	
					reviewed daily by the	
	and that appropriate, timely, and effective intervention occurs3. Routine Medical				DNS/designee with follow-up using the daily minutes tool to	
					ensure physician orders are in	
		ymptoms and unusual			place and being followed.	
		cumented in the medical			· Non-compliance with these	
	_	nunicated to the attending		procedures and training will result in disciplinary action.	sult	
		otly. Routine changes are				
		in physical and mental			How the corrective action(s) w	ill l
					be monitored to ensure the	
		nal laboratory and x-ray			deficient practice will not recur	
		ot life threatening. b.			The change of condition and the change of condition and the change of conditions are changed on the change of conditions and the change of conditions are changed on the change of conditions and the change of conditions are changed on the change of conditions and the change of change	
		rge is responsible for			physician notification daily tool be utilized daily x 4 weeks,	I WIII
	notification of pl	-			bi-weekly x 2 months, monthly	x 3
		ple party prior to end of			and for 3 quarters thereafter.	
	_	hen a significant change			Findings from the CQI proce	
		condition is noted. c. If			will be reviewed monthly and a	
	unable to reach t				action plan will be implemente as needed for any deficient	u
		ole party, all calls to			practices above the 95%	
	physicians or ex-	changes and			threshold.	
	family/responsib	ole party requesting				
	callbacks will be	e documented in the				
	medical record.	d. If the physician has				
ı		call by the end of the				
		ing nurse will be notified				
		If unable to contact				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 5 of 43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 02/24/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	attending physician or alternate timely, the Medical Director will be notified for response and intervention for the resident change of condition. f. Document resident change of condition and response in the medical record. Documentation will include time and family/physician response. g. The licensed nurse responsible for the resident will continue assessment and documentation in the medical record every shift until the residents condition has stabilized" 3.1-5(a)(3)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 6 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPL	ETED
		155697	A. BUILDING B. WING 02/24/2012			2012	
			B. WIN		PDDEGG CVTV CTATE UP CODE		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
		ND OWN FD AN IDOMO OFFITED			ITTLE LEAGUE BLVD		
CLARK R	CLARK REHABILITATION AND SKILLED NURSING CENTER			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0203 SS=D	483.12(a)(4)-(6) NOTICE REQUITRANSFER/DIS Before a facility to resident, the facing and, if known, a representative of or discharge and writing and in a launderstand; recorresident's clinica notice the items of this section. Except when specific for this section must least 30 days be transferred or discharge require this section must least 30 days be transferred or discharge, under section; an immer endangered und the resident's he allow a more immedischarge, under section; an immer required by the resident of a resident of this section transfer or discharger or discha	REMENTS BEFORE CHARGE transfers or discharges a lility must notify the resident family member or legal f the resident of the transfer d the reasons for the move in anguage and manner they ord the reasons in the il record; and include in the described in paragraph (a)(5)(ii) ne notice of transfer or ed under paragraph (a)(4) of t be made by the facility at fore the resident is scharged. Inade as soon as practicable or discharge when the health the facility would be er (a)(2)(iv) of this section; salth improves sufficiently to mediate transfer or or paragraph (a)(2)(i) of this ediate transfer or discharge is esident's urgent medical ragraph (a)(2)(ii) of this ident has not resided in the		TAG	DEFICIENCY)		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 7 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE S	(3) DATE SURVEY	
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155697	B. WIN	3 <u> </u>		02/24/2012	
	VIDER OR SUPPLIER	ND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility residents disabilities, the matelephone number for the protection developmentally established under Developmental Embers and telementally in the Protection and Individuals Act.	mbudsman; for nursing with developmental nailing address and er of the agency responsible and advocacy of disabled individuals er Part C of the Disabilities Assistance and er and for nursing facility e mentally ill, the mailing phone number of the agency ne protection and advocacy ividuals established under and Advocacy for Mentally Ill review and interview, the	F02	03			03/25/2012
fa Tri re lo re #9 Fri TI re re or th	ransfer/Dischar cason for, date of cation, for 1 of eviewed in a sar (99) inding includes the clinical reco- eviewed on 2/22 esident was disc in 1/5/12. The rate Transfer/Disc on 2/24/12 at 8:12 the Medical Reco- ter other facility	ge form which included of, and/or transfer 2 closed records inple of 15. (Resident rd for Resident #99 was 2/12 at 4:25 p.m. The charged to another facility ecord lacked a copy of			It is the practice of this provide ensure all residents are made aware of any potential transfer/discharge in accordan with the thirty day required notification. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #99 has been discharged from this facility beyond the timeframe to appeat the discharge. On 3/9/12 a cof our discharge notice was mailed to ensure resident #99 had a copy for their records. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taked. An IDT review on 3/9/12	ce l al opy	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 8 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155697	B. WING		02/24/2012
NAME OF D	DOMINED OF CLIPPLIED		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER		517 N L	ITTLE LEAGUE BLVD	
		ND SKILLED NURSING CENTER		SVILLE, IN 47129	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	3.1-12(a)(9)(B)			revealed no residents that currently have the potential to	he
	3.1-12(a)(9)(C)			affected.	
	3.1-12(a)(9)(E)			Any resident discharged will	ı
	3.1-12(a)(9)(G)			have appropriate discharge fo	rms
				completed.	
				What measures will be put in	ito
				place or what systemic	
				changes you will make to	
				ensure that the deficient practice does not recur?	
				· Effective 3/9/12 all future	
				discharge/transfers will be	
				reviewed by the IDT before su	ch
				action, when possible, or during	ng
				the next IDT meeting to verify	
				proper written notification has occurred.	
				Any resident identified during	na
				IDT review without proper	.9
				notification will receive the	
				appropriate forms the day of the	ne
				IDT meeting.	
				How the corrective action(s)	
				will be monitored to ensure t	he
				deficient practice will not	
				recur?	
				Medical Records Coordinato	r
				will report monthly for six	
				months via the CQI meeting	
				number of discharges for the month and verification each	}
				received appropriate and	
				complete forms/notification	
				- Complete Termornounounounou	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 9 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155697				02/24/2012	
	B. WING				ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
		ND OKULED NUDOING CENTED			ITTLE LEAGUE BLVD		
CLARK REHABILITATION AND SKILLED NURSING CENTER				CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0204 SS=D	TRANSFER/DIS A facility must preparation to a record the facility failed preparation to a reference of the facility failed preparation to a reference of the facility failed preparation to a reference of the facility failed preparation to a reviewed for discovered for discover	FOR SAFE/ORDERLY CHRG ovide sufficient preparation oresidents to ensure safe effer or discharge from the review and interview, to provide sufficient resident prior to being deficient practice escharged residents charge planning in a idents. (Resident #98)	F02	04	It is the practice of this provide ensure all residents are made aware of any potential transfer/discharge with sufficie preparation and orientation to ensure safe and orderly transfer/discharge from the facility.		03/25/2012
	#98 on 2/22/2012 the resident had a included, but we post fractured tib weakness, diabet hypotension. On 9/1/2011, a N Discharge was is effective 10/1/20 has failed, after rappropriate notice not been made un for a stay in a nu indicated the residence.	re not limited to: status via with fibula, muscle es mellitus type I and lotice of Transfer or sued to the resident 111, due to "The resident			What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #98 is no longer a resident of this facility. Reside was discharged per request to facility the resident chose. How will you identify other residents having the potentiat to be affected by the same alleged deficient practice and what corrective action will be taken? An IDT review on 3/9/12 indicated no resident in the fact at this time has the potential to affected. Residents discharged will he adequate discharge planning. What measures will be put in place or what systemic	ent a d d d d d d d d d d d d d d d d d d	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 10 of 43

i i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155697	B. WING			02/24/2	2012
NAME OF D	DOVIDED OD GUDDI IED		ST	TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		5′	17 N LI	ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		FATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG			DATE
		disciplinary Progress			changes you will make to ensure that the deficient		
	Note [IDT] indicated the team spoke with the family via phone about Medicaid and				practice does not recur?		
					practice does not recui :		
	the issuing of the	30 day notice for			· Effective 3/9/12 all future		
	non-payment. Do	ocumentation also noted			discharge/transfers will be		
	the resident refus	sed to attend this meeting.			reviewed by the IDT before su		
		٥			action, when possible, or during	ng	
	The next note res	garding discharge was an			the next IDT meeting to verify		
	_	Progress Note dated			proper written notification has occurred with appropriate		
		•			discharge plans developed 14		
	9/28/2011, in which the family was courtesy called to remind them that APS				days prior to discharge and su		
	_				discharge/transfer has all		
	-	e Services] would be			applicable safety/orientation ite	ems	
		w-up. The note also			addressed and documented.		
		dent was informed she			 Any resident identified during IDT review without proper 	ng	
	was to be dischar	ged to her daughter's			notification of safety/orientation	nn	
	house.				issues will receive the	,,,	
					appropriate information the da	y of	
	Documentation v	vas lacking of any type of			the IDT meeting.		
	discussion with t	he resident or family					
	between 9/1 and	10/1/2011 to determine			How the corrective action(s)		
	what services, ea	uipment or needs might			will be monitored to ensure t deficient practice will not	ne	
	be needed once t				recur?		
	discharged.						
	aischargea.				· Social Services Director will		
	During on inter-	low with the Duciness			report monthly for six months		
	_	iew with the Business			the CQI meeting the number of	of	
	_	on 2/23/2012 at 10:10			discharges for the month and		
	-	ed that after researching			verification each received appropriate		
the files, she could only guess the notice was issued because the resident did not					notification/communication		
					regarding safety/orientation		
	make her Medicaid application in a timely				issues and discharge planning	j.	
manner causing her to be responsible for the bill the first 3 months she was							
	admitted to the fa						
							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	JETIPLE CO.	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155697	A. BUII		00	COMPLETED 02/24/2012	
		155091	B. WIN			02/24/	ZU 1Z
NAME OF P	ROVIDER OR SUPPLIER	ł		1	DDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		2:10 p.m., the Medical					
		r presented a copy of the					
	_	policy on "Social					
	Services Dischar	ge procedures." Review					
	of this policy at t	this time included, but					
	was not limited t	o: "4. The discharge					
	plan will be form	nulated and reviewed					
	with the resident	responsible party					
	fourteen days pri	ior to discharge from the					
	facility. The outo	come of the conference					
	will be documen	ted in the IDT note7.					
	While completio	n of the discharge plan of					
	care involves all	appropriate disciplines,					
	Social Services v	will ensure that it has					
	been completed 1	prior to the resident's					
		al Services are the					
	discharge planne						
		make sure all education					
	_	in place and documented					
		at being discharged."					
	prior to wrosiaen	a company goal.					
	3.1-12(a)(21)						
	3.1 12(u)(21)						
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 12 of 43

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697	SURVEY
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER (X4) ID PREFIX TAG FO250 FO250 FO250 FO250 A83.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129 STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDER STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY) FO250 IT is the practice of this provider to ensure that each resident receives assistance in discharge planning .	LETED
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER (X4) ID PREFIX TAG FOUNDES PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FO250 SS=D FO250 A83.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129 ID PROVIDES PLAN OF CORRECTION FROUDES PLAN OF CORRECTION FROU	/2012
CLARK REHABILITATION AND SKILLED NURSING CENTER (X4) ID PREFIX TAG FO250 SS=D PROVIDER PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129 SID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE (REACH CORRECTIVE ACTION SHOULD BE (ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG FO250 It is the practice of this provider to ensure that each resident receives assistance in discharge planning .	
CLARK REHABILITATION AND SKILLED NURSING CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F0250 SS=D A83.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient CLARKSVILLE, IN 47129 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPR	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F0250 SS=D 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient PREFIX TAG PR	
F0250 SS=D F0250 SS=D F0250 SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient F0250 TAG CROSS-REFERENCED TO THE APPROPRIATE TAG TAG TAG TAG TAG TAG TAG	(X5)
F0250 SS=D 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient F0250 It is the practice of this provider to ensure that each resident receives assistance in discharge planning.	COMPLETION
PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient F0250 It is the practice of this provider to ensure that each resident receives assistance in discharge planning.	DATE
psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient F0250 It is the practice of this provider to ensure that each resident receives assistance in discharge planning.	
Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient F0250 It is the practice of this provider to ensure that each resident receives assistance in discharge planning.	
facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient ensure that each resident receives assistance in discharge planning .	
assistance in discharge planning in preparation to return home. This deficient received assistance in discharge planning in preparation to return home.	03/25/2012
assistance in discharge planning in preparation to return home. This deficient planning .	
preparation to return home. This deficient	
practice affected 1 of 2 discharged What corrective action(s) will	
residents reviewed for discharge planning be accomplished for those	
in a sample of 15 residents. (Resident residents found to have been	
#98) affected by the alleged deficient practice?	
Resident #98 is no longer a	
Finding includes: resident of this facility. Resident	
was discharged per request to a	
Review of the clinical record for Resident facility the resident chose.	
#98 on 2/22/2012 at 4:30 p.m., indicated	
the resident had diagnoses which residents having the potential	
included, but were not limited to: status to be affected by the same	
post fractured tibia with fibula, muscle alleged deficient practice and	
weakness, diabetes mellitus type I and what corrective action will be	
hypotension. taken?	
• An IDT review on 3/9/12	
On 9/1/2011, a Notice of Transfer or indicated no resident in the facility at this time has the potential to be	
Discharge was issued to the resident affected.	
effective 10/1/2011, due to "The resident . Any resident discharged will	
has failed, after reasonable and have appropriate discharge forms	
appropriate notice, to pay or payment has	
not been made under Medicare/Medicaid	
for a stay in a nursing facility." The notice What measures will be put into	
indicated the resident was going to be place or what systemic	
discharged to her daughter's home changes you will make to	
ensure that the alleged	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 13 of 43

STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPL	ETED
		155697	A. BUII B. WIN			02/24/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD		
	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
		disciplinary Progress			deficient practice does not recur?		
		he team spoke with the		· Effective 3/9/12 all future			
	family via phone about Medicaid and the				discharge/transfers will be		
	issuing of the 30	day notice for			reviewed by the IDT before su	ıch	
	non-payment. D	ocumentation also noted			action, when possible, or duri	-	
	The next note regarding discharge was an Interdisciplinary Progress Note dated 9/28/2011, in which the family was courtesy called to remind them that APS [Adult Protective Services] would be				the next IDT meeting to ensur		
			1		social services are involved in transfer/discharge process.	ı uı c	
					Any resident identified duris	ng	
					IDT review without appropriate	e	
					social services involvement w		
					receive such services day of t	he	
					IDT meeting through discharge/transfer		
	-	ow-up. The note also			disoriarge/transier		
		ident was informed she			How the corrective action(s)		
		rged to her daughter's			will be monitored to ensure	the	
	house.	iged to not daughter s			deficient practice will not		
	nouse.				recur? i.e., what quality		
	Dogumentation	was lacking in the Social			assurance program will be p into place.	ut	
		of any type of discussion			into piace.		
					· Social Services Director will	II	
		t or family between 9/1			report monthly for six months		
		determine what services,			the CQI meeting the number of	of	
		eds might be required			discharges/transfers for the month and verification each		
	once the residen	t was discharged.			received appropriate social		
					services involvement, including	ıg	
		re Plan by Social Services			discharge planning.		
	•	s not limited to, the	1				
	following:						
		charge/psychosocial well					
	_	and family may need to	1				
	coordinate comm	nunity resources for					
	discharge plan: assisted living facility."						
	- "Goal: Resident/family will provide						
	information on s	special needs/services or					
		s as discharge plan is					

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN			02/24/	2012
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	R	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	coordinated."	CESC IDENTIFTING INFORMATION)		IAG	,		DATE
		mplete discharge forms					
	and review with	-					
		dent/family to express					
	their expectation						
	- Provide inform	_					
	community reso						
		urccs					
	On 2/23/2012 at	2:10 p.m., the Medical					
		r presented a copy of the					
		policy on "Social					
	1	rge procedures." Review					
		this time included, but					
		to: "Discharge planning					
		admission3. Social					
		cument updates on					
		an meetings, and any					
		n the discharge plan in the					
	_	ogress note4a. Social					
	_	cument in the social					
		s note any care plan					
		or declines setting up					
		al Services is responsible					
		with resident/responsible					
	party and the app	•					
		ces to assist in education					
		for discharge7. While					
		e discharge plan of care					
		ropriate disciplines,					
		will ensure that it has					
		prior to the resident's					
	_	al Services are the					
	discharge planne						
		make sure all education					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 15 of 43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE : COMPL	
THEFTERN	or conduction	155697	A. BUII			02/24/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	J=, = 1/	· -
NAME OF P	PROVIDER OR SUPPLIER	£			ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		in place and documented		TAG			DATE
		it being discharged."					
	prior to a residen	it being discharged.					
	On 2/24/2012 at	11:00 a.m., the acting					
		ing [DoN] presented a					
		Description" for the					
		orker. Review of this					
	-	" included, but was not					
	limited to: "Ess	sential Position					
	FunctionsAdvi	ses appropriate referrals					
	to minimize soci						
		harge. Coordinates					
	discharge planni						
	_	ng, including advice and					
		unity resources before or					
	during relocation	1"					
	3.1-34(a)						
	3.1-34(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 16 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL			JLTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED	
		155697	A. BUII		- <u>-</u> -	02/24/2012	
			B. WIN		ADDRESS SITE STATE SID CODE		
NAME OF P	ROVIDER OR SUPPLIER	4		l	ADDRESS, CITY, STATE, ZIP CODE		
		ND CKU I ED NUIDCING CENTED			LITTLE LEAGUE BLVD		
CLARK R	KEHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0253 SS=C	483.15(h)(2)	G & MAINTENANCE					
33-0	SERVICES	O & MAINTENANGE					
	The facility must provide housekeeping and maintenance services necessary to maintain						
		ly, and comfortable interior.					
	Based on observa	ation and interview, the	F02	53	It is the practice of this provide	er to	03/25/2012
		ensure furniture and			ensure housekeeping and		
	_	clean in 1 of 2 dining			maintenance services to maint a sanitary, orderly, and	tain	
	rooms, 1 of 1 the	erapy room, and 1 of 1			comfortable interior.		
		ad 3 of 43 resident rooms.					
	This deficient pra	actice had the potential to			What corrective action(s) will		
	affect 75 of 75 ci	-			be accomplished for those		
		arrent residents.			residents found to have been	1	
	Eindings in aluda				affected by the alleged		
	Findings include				deficient practice? · All chairs in the dinning roor	_	
	0 00/04/40 4				were affectively cleaned on		
	On 02/21/12, the	following was observed:			2/25/2012.		
					· All chairs in the therapy		
	-	the wood frames of 13 of			department were affectively		
	13 chairs in the r	nain dining room were			cleaned on 2/25/2012.		
	soiled with heavy	y dust that rolled up when			Box fan in laundry was clea by bayaskapping an 2/25/42	ned	
	swiped with the	fingers. The vents on			by housekeeping on 2/25/12 On 3/9/12 all bed frames in	the	
	_	ice machine were soiled			facility were appropriately		
	with heavy dust.	In interview with the			cleaned.		
	=	at this time, she indicated			· The wall in room 24 was		
	, ,	s responsible for cleaning			repaired accordingly on 3/12/1	2.	
	the ice machine.	, responsible for eleming			All mattress covers were		
	the lee machine.				cleaned by housekeeping on cleaned by housekeeping on cleaned before 2/25/12.	ו	
	2 At 12:09 n m	, the wood frames of 3 of			Ceiling vents in the main dir	ning	
	_	erapy room were soiled			room were cleaned by		
		* *			housekeeping on 2/25/12.		
	_	In interview with a			· Ice machine vents in the ma	ain	
	-	ame time, she indicated			dining room was cleaned by maintenance on 2/25/12.		
		eans the chairs and			maintenance on 2/20/12.		
	therapy cleans th	erapy equipment.			How will you identify other		
					residents having the potentia	al	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 17 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLE	ETED
		155697	B. WIN			02/24/2	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3. At 12:13 p.m	., a box fan on the clean			to be affected by the same		
	side of the laund	ry was soiled with heavy			alleged deficient practice and		
	dust on the grill and blades. The laundry				what corrective action will be	•	
		erview at this time, when			taken?	.4:-1	
		the fan was cleaned,			 All residents have the poter to be affected, all bed frames 	iliai	
		· · · · · · · · · · · · · · · · · · ·			were appropriately cleaned on		
	replied "maybe 1 time per week."				3/12-3/17/12. An IDT review o		
	4 0 02/22/12	-4.0-21			3/9/12 indicated no resident in	the	
	4. On 02/23/12 at 8:21 a.m., two ceiling				facility at this time has the		
		n dining room were soiled			potential to be affected.		
		The vents were located			· Ice Machine vents, Box Far		
	directly over a ta	able utilized by residents			Mattress covers and Ceiling ve were cleaned on/by 2/25/12 by		
	for meals and ac	tivities.			housekeeping	' l	
					, neaconcoping		
	On 02/24/12 the	following was observed:			What measures will be put in	to	
					place or what systemic		
	5 At 8.29 a m	a box fan in room 30 was			changes you will make to		
		y dust on the guard and			ensure that the alleged		
		frames of both beds were			deficient practice does not		
					recur?	d	
	I .	y dust that rolled up when			 Effective 3/12/12 an update room cleaning schedule was 	u	
	_	finger. A strong odor of			created to ensure routine		
	1	odor was noted on bed 1.			cleaning of bed frames and far	ns,	
	The mattress cov	ver was soiled with food			as well as dining room furnitur		
	crumbs in the cre	evices.			Housekeeping in-serviced by		
					Environmental Director by		
	6. At 8:33 a.m.,	in room 24 the frame of			3/19/12 on new schedule and current laundry cleaning sched	ا مایا	
	· ·	ns were soiled heavy			which includes all fans in laund		
		ooard just inside the door			area.	ω. y	
		split in approximately 6					
	inch area.	spire in approximatory o					
	men area.				How the corrective action(s)		
	-				will be monitored to ensure t	he	
		the bed frame in room 65			deficient practice will not		
		heavy dust. The room			recur? i.e., what quality		
	was noted ready	for resident occupancy.			assurance program will be p	ut	
ı					into place.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 18 of 43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 02/24/2012
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER		ITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) • Environmental Services Director will do random audit cleaning is complete to verify compliance. Audits will be conducted weekly for four we then monthly for six months to verify adherence to schedule. • Results of audits will be reported to CQI committee.	after DATE eks

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 19 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			02/24/2012	
			P. "111V		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER	1	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY COARE PLAN The services profacility must be profacility must be profacility failed to to treat a urinary followed for 1 of physician orders of 3. (Resident #Findings include The clinical recorreviewed on 2/23 resident's diagnor not limited to, do and urinary tract 11 a.m., the physician treat a urinary (milligrams) BII days. On 2/23/12 at 11 with LPN (Licente indicated he was unable to ge Macrobid clarific of the discrepance the concern onto	QUALIFIED PERSONS/PER ovided or arranged by the provided by qualified persons ith each resident's written review and interview, the ensure physician orders tract infection were f 3 residents reviewed for in a supplemental sample #70)	F02		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 70's antibiotic w started. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potent to be affected by the alleged deficient practice. Licensed Nursing staff will be re-educated by 3/13/12 by the DNS/designee on timely physician notification, and following physician's orders. Petest completed. All physician orders are reviewed daily by the DNS/designee with follow-up using the CQI minutes tool to ensure physician orders are in place and being followed. Non-compliance with these practices will result in further education including disciplinariaction. Director of nursing	as the e e e ntial	03/25/2012
	been started.				services/designee is responsil to ensure compliance.	ble	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 20 of 43

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		A. BUILI	DING	NSTRUCTION 00	(X3) DATE S COMPL 02/24/	ETED	
	PROVIDER OR SUPPLIE	L R AND SKILLED NURSING CENTER	B. WING	STREET A	IDDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Review of the F Administration in not limited to "N mouth) BID x 7 medication was the nurse was ci on 2/22/12. The reverse side of t	ebruary 2012 Medication Record included, but was Macrobid 500 mg po (by Days" indicated the not given as the initial of reled for the 9 p.m. dose e explanation given on the the Medication Sheet obid - need clarification			What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur. Licensed Nursing staff will be re-educated 3/13/12 by the DNS/designee on timely physician notification, and following physician's orders. Plest completed. All physician orders are reviewed daily by the DNS/designee with follow-up using the CQI minutes tool to ensure physician orders are in place and being followed. Non-compliance with these practices will result in further education including disciplinar action. Director of nursing services/designee is responsible to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. The CQI audit tools for physician notification and char of condition will be utilized weak at weeks, bi-weekly x 2 mont monthly x 3 months and quarte thereafter. Findings from the CQI processing the reviewed monthly and a action plan will be implemented for thresholds below 95%.	y ble he ekly hs, erly ess an	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155697	B. WIN			02/24/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			LITTLE LEAGUE BLVD		
CLARKE	PEHARII ITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
					10 11 12 12 12 12 12 12 12 12 12 12 12 12		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309	483.25						
SS=D		SERVICES FOR HIGHEST					
	WELL BEING						
		ust receive and the facility					
	-	necessary care and nor maintain the highest					
	practicable physi	•					
		Il-being, in accordance with					
		ive assessment and plan of					
	care.						
	Based on record	review and interview, the	F03	09	What corrective action(s) will	l	03/25/2012
		ensure a resident's pain			be accomplished for those		
	_	-			residents found to have been	1	
		ged for 1 of 2 residents			affected by the deficient		
	•	n management in a			practice?		
	sample of 15. (R	Resident #45)			· Resident # 45 no longer		
					resides at this facility.		
	Findings include	:			l	_	
					How other residents having t		
	The clinical reco	rd for Resident #45 was			potential to be affected by the		
		1/12 at 1 p.m. The			same deficient practice will be identified and what corrective		
		•			action(s) will be taken?	9	
	_	ses included, but were			All residents have the potential residents.	ntial	
	not limited to: rig	_			to be affected by the alleged	liai	
	amputation and c	cancer of the bladder.			deficient practice.		
	Review of the PI	RN (as needed)			The licensed nurses will be	in	
	Medication Reco	ord for February 2012			serviced by the DNS/designee	,	
		ident was receiving			3/13/12 on pain management.		
		mmediate Release) 5 mg			Post test included.		
	`	, •			· All residents receiving prn p		
	` • ′	et. Take 1 tablet by mouth			medications have been review		
	_	needed for moderate pain			to ensure that the medication i effective in controlling their pai		
		IR 5 mg, take 2 tablets			Trends in complaints of pair		
	(10mg) by mouth	n every 4 hours as needed			specific locations have been	•	
	for severe pain.	The original order for			reviewed to ensure the physici	an	
	Oxycodone IR w	vas ordered on 1/20/12			has been contacted for further		
	and signed by the				orders.		
	and bigiled by the	e pirjoieiuii.			The director of nursing		
	D : 04 5	II D 10			services/designee is responsib	ole	
	Review of the Do	ose Usage Record for			to ensure compliance		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 22 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DDIC	00	COMPL	ETED
		155697	A. BUII B. WIN	LDING		02/24/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			LITTLE LEAGUE BLVD		
CLARK F	REHARII ITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
						1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	ndicated the following:			What measures will be put in	to	
	Oxycodone IR 5 mg tablets (2) for 10 mg were given 2 to 5 times in a 24 hour period on the following days: February 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19.				place or what systemic	ito	
					changes you will make to		
					ensure the deficient practice		
					does not recur:		
	Review of the In	itial Minimum Data Set			· The licensed nurses will be	in	
					serviced by the DNS/designed		
	Assessment dated 1/27/12, indicated a care plan for pain management				3/13/12 on pain management.		
		· ·			Post test included. All pain medications ordere	d	
	completed. The care plan completed on				have been reviewed to ensure		
	2/15/12 included, but was not limited to:				that the medication is effective		
	"Problem Start Date 2/15/12 Resident has				controlling their pain.		
	pain related to:	decreased mobility, right			· Trends in complaints of pair	า	
	above knee amp	utation, requires			specific to locations have beer		
	assistance to con	nplete ADL's (Activities			reviewed to ensure the physic		
	of Daily Living)	, bladder cancer, PVD			has been contacted for further	•	
	1	ılar disease), sacral			orders. The director of nursing		
	~ ~	pack wound. Approach:			services/designee is responsible	ole	
		2 Administer meds as			to ensure compliance		
					Non-compliance will result	in	
	-	dication interventions			further education including		
	such as rest, quie				disciplinary action.		
	-	ered., Notify MD if pain is			· Nurse will document		
	unrelieved and /o	or worsening."			effectiveness of pain medication on the MAR.	on	
					OII LIIC IVIAIN.		
	On 2/23/12 at 3:	40 p.m., in interview with			How the corrective action(s)		
	the Corporate RI	N, she indicated the pain			will be monitored to ensure t	he	
	•	for breakthrough pain.			deficient practice will not		
		the sign out record, she			recur:		
		ysician would be called			The CQI audit tool for pain		
		ident was taking the			management will be utilized da		
					x 4 weeks, bi-weekly x 2 mont	ns,	
	medication on a	routine basis.			monthly x 3 months and for 2 quarters thereafter.		
					Findings from the CQI proce	ess	
	On 2/24/12 at 9	a.m., the Administrator			and trends will be reviewed		
	provided a pain	assessment dated 2/3/12			monthly and an action plan wil	ll be	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155697	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	PLETED 4/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTE	517 N	ADDRESS, CITY, STATE, ZIP CO LITTLE LEAGUE BLVD (SVILLE, IN 47129	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	at 4:22 p.m., which included, but was not limited to: "Yes" was answered to the following: currently on routine pain meds, experiencing pain, "Have you had pain or hurting at any time in the last 5 days?" "Has pain made it hard for you to sleep at night over the past 5 days?" "Have you limited your day-to-day activities because of pain?" "Pain in left leg, right hip and back, severe, almost constantly, throbbing, nothing so far has helped much, chronic since admission." 3.1-37(a)		implemented for thresho	old below	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 24 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155697	B. WING	G		02/24/2012	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315 SS=D	483.25(d) NO CATHETER, BLADDER Based on the resident who ent indwelling cathet the resident's clir that catheterizati resident who is in receives approprious prevent urinary restore as much possible. Based on record the facility failed urinary tract infe timely for 1 of 2 history of urinary supplemental same Findings: The clinical reconstruction reviewed on 2/23 resident's diagnous not limited to, deand urinary tract the doctor ordere urinary tract infe (milligrams) BID days. Resident Progress were not limited	PREVENT UTI, RESTORE sident's comprehensive facility must ensure that a ers the facility without an er is not catheterized unless nical condition demonstrates on was necessary; and a ncontinent of bladder riate treatment and services y tract infections and to normal bladder function as review and interview, to ensure treatment for a ction was implemented residents reviewed with a y tract infection in a mple of 3. (Resident #70) and for Resident #70 was sold at 9:20 a.m. The ses included, but were ementia, diabetes type II infection. On 2/21/12, and Macrobid (to treat a ction) 500 mg of (two times a day) for 7 as Notes included, but to: 02/20/12 6 p.m. by in today to visit with	F03	TAG	F-315 No Catheter, prevent UTI, Restore bladder What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice? Resident # 70's antibiotic w started. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the pote to be affected by the alleged deficient practice. Licensed Nursing staff will be re-educated 3/13/12 by the DNS/designee on timely physician notification, and following physician's orders. Petest completed. All physician orders are reviewed daily by the	as the e oe e ntial	03/25/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 25 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155697	B. WIN			02/24/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8		1	LITTLE LEAGUE BLVD	
CLARK F	REHABII ITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG				TAG	DNS/designee with follow-up	DATE
	1	concerned because			using the daily minutes tool to	
		er R (right) side was			ensure physician orders are in	
	hurting. Nurse c	checked resident R side			place and being followed.	
	and asked reside	nt if it hurt when			· Non-compliance with these	
	touched. Reside	nt stated "not that bad but			practices will result in further	
	just a little." No	bruising noted, no visual			education including disciplinar	у
	3	(symptoms & signs) of			action.	
		otified. Family stated			 Director of nursing services/designee is responsit 	nle
		t hasn't been acting right'			to ensure compliance.	
	-	U/A (urinalysis) on			What measures will be put in	ito
	resident"				place or what systemic	
		was lacking of a further			changes will be made to	
		e resident's urinary			ensure that the deficient	
	output, color, od	or and pain or burning on			practice does not recur.	
	urination.				Licensed Nursing staff will be a second of the second	pe
	"MD notified,	new order for U/A C&S			re-educated 3/13/12 by DNS/designee on timely	
	(culture & sensit	ivity) to be done via			physician notification, and	
	`	D will be in tomorrow to			following physician's orders. P	ost
	_	nily notified of new order			test completed.	
	for U/A"	mily notified of new order			All physician orders are	
	101 U/A				reviewed daily by the	
	00/00/10 (00 D)	(DNS/designee with follow-up	
		M "M.D. in to see res,			using the daily minutes tool to	
		tibiotic received, related			ensure physician orders are in place and being followed.	
	to UTI, family a	nd pharmacy notified."			Non-compliance with these	
					practices will result in further	
	02/23/2012 8:53	AM "Physician to see			education including disciplinar	y
	resident in facilit	ty. New clarification			action.	
		oid to be changed to 100			· Director of nursing	-1-
		ch) BID. New order for			services/designee is responsible to ensure compliance.	ле
		lneys, ureters for			How the corrective action(s)	
	hematuria. fami				will be monitored to ensure t	he
	nematuma. milli	iy nomicu.			deficient practice will not rec	
	D . 04 **				i.e., what quality assurance	,
	Review of the U	-			program will be put into plac	e?
	02/22/2012 at 23	3:30 (11:30 p.m.)			The CQI audit tools for	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 26 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPL	ETED
		155697	A. BUII B. WIN			02/24/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	2		SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		s not limited to: "Clarity			physician notification and char	•	
	Turbid (cloudy)	Abnormal (Normal -		of condition will be utilized weekly x 4 weeks, bi-weekly x 2 months,			
	clear); Blood 3+	- Abnormal (Normal -			monthly x 3 months and quart		
	Negative); Prote	in 2+ Abnormal (Normal			thereafter.	,	
	- negative); Nitri	te Positive normal			 Findings from the CQI proc 		
	negative; Leuko	cytes, 4+ (Normal -			will be reviewed monthly and		
	•	e Blood Cells > (greater			action plan will be implemente for thresholds below 95%.	ed	
	~ //	l -Negative) a culture			lor tillesholds below 95%.		
	would be perform	• /					
	would be perior	neu.					
	Review of the Fe	ebruary 2012 Medication					
		Record included, but was					
		facrobid 500 mg po (by					
		Days" indicated the					
		not given as the initial of					
		reled for the 9 p.m. dose					
		explanation given on the					
	reverse side of the	ne Medication Sheet					
	indicated "Macro	obid - need clarification					
	order."						
	On 2/23/12 at 11	:37 a.m.,, in interview					
		nsed Practical Nurse) #2,					
	`	worked second shift and					
		et the order clarified. He					
	_	ern onto the next shift					
	_	the ordered medication					
	had not been star						
	nau noi been stai	iteu.					
	On 2/22/12 at 2.	40 n m in intorvious with					
		40 p.m., in interview with					
	_	egistered Nurse, she					
	_	acy questioned the dose					
		500 mg tablets, only 50					
	and 100.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 27 of 43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/24/2012
		100007	B. WING	LDDDDGG GYMY GWLWD GYD GODD	02/24/2012
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD	
CLARK F		AND SKILLED NURSING CENTER		SVILLE, IN 47129	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
				CROSS-REFERENCED TO THE APPROPRIA	IE
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 28 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		155697	B. WIN	G		02/24/	2012
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0328 SS=D	483.25(k) TREATMENT/C/ The facility must receive proper tr following special Injections; Parenteral and e Colostomy, urete Tracheostomy care Foot care; and Prostheses. Based on record interview, the fact proper care was a tracheostomy care resident reviewed a sample of 15. (Findings include Review of the cliff # 50 on 02/21/20 indicated diagnoral indicated diagn	ARE FOR SPECIAL NEEDS ensure that residents eatment and care for the services: enteral fluids; erostomy, or ileostomy care; are; ing; ;; review, observation and cility failed to ensure the given related to re. This affected 1 of 1 d with a tracheostomy in Resident #50) d: inical record for Resident 012 at 1:15 p.m., sees including, but not post motor vehicle estomy (airway tube), the (feeding tube), seizures. 2:00 p.m., during are given to Resident #50, the (RN) # 1 put on gloves	F03		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #50 has passed at How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potent to be affected by the alleged deficient practice. Licensed Nursing staff will be re-educated 3/13/12 on tracheostomy care by the DNS/designee. Post test included. Licensed Nurses will be checked off on tracheostomy on or before 3/25/12 by the State Development Coordinator/designee. Non-compliance with these	l way the e e tial	DATE 03/25/2012
	RN # 1 removed	oxygen and removed old			practices will result in further education including disciplinar	v	
					action.	, l	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 29 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155697	A. BUII B. WIN			02/24/2012
			Γ. ""		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	_	ound outer trachea and			 Director of nursing services/designee is responsil 	nle l
then removed inner cannula and removed				to ensure compliance.	Sic	
	gloves.					
	RN # 1 applied s	sterile gloves and poured			What measures will be put in place or what systemic	ito
	hydrogen peroxi	de into container and			changes will be made to	
	proceeded to we	t a cotton applicator with			ensure that the deficient	
	solution and wip	ped inside trachea.			practice does not recur?	
	RN # 1 wet a ne	w cotton applicator and			 Licensed Nursing staff will to re-educated on tracheostomy 	J C
		e outside of the outer			care 3/13/12 by the	
	_	Resident #50's skin and			DNS/designee. Post test included.	
		ea with same cotton			· Licensed Nursing staff will	
		ica with same cotton			conduct validation audits for	
	applicator.				tracheostomy care on or befor	l l
	RN # 1 took off	sterile gloves and opened			3/25/12 by the Staff Developm	nent
	normal saline (N	IS) and put on non-sterile			Coordinator/designee. Licensed Nursing staff will	
	gloves and proce	eeded with rinsing off the			conduct validation audits for h	
	trachea.				washing on or before 3/25/12	by
	RN # 1 took a 42	x4 pad and wet it with the			the Staff Development Coordinator/designee.	
	NS and wiped in	side the trachea and then			· Non-compliance with these	
	got a new 4x4 pa	ad and wet it with the NS			practices will result in further	
	1	nd outside and on			education including disciplinar action.	y
	resident's skin.					
		pe cleaner and dried			How the corrective action(s) will be monitored to ensure t	.h.a
	1	•			deficient practice will not rec	
		a and used new pipe			i.e., what quality assurance	,
	_	ed around outside and on			program will be put into plac	e?
	resident's skin.				The CQI skills check off for	
	RN #1 put a new	trach collar on and			tracheostomy care will be utilize weekly x 4, bi-weekly x 2 mon	l l
	fastened, and the	en removed gloves and			monthly x 3 and quarterly	u10,
	washed hands.				thereafter.	
					· Findings from the CQI proc	l l
					will be reviewed monthly and a	l l

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 02/24/2012
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	
CLARK I	REHABILITATION AND SKILLED NURSING CENTER		LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	On 2/22/2012 at 5:00 p.m., review of the		for thresholds below 95%.	
	policy and procedure for "Tracheostomy			
	Care" indicated, but was not limited to;			
	"Skillwash handsdry tracheostomy			
	area thoroughly using a 4x4 gauze			
	sponge"			
	On 2/22/2012 at 4:00 m === i=====			
	On 2/22/2012 at 4:00 p.m., in an			
	interview with the Corporate RN # 2, she			
	indicated she would expect that nursing			
	would wash their hands before and after			
	tracheostomy care.			
	On 2/24/2012 at 1:40 p.m., review of the			
	current "HAND WASHING POLICY			
	AND PROCEDURE" provided by			
	Administration indicated, but was not			
	limited to;			
	"A. Purpose			
	1. To prevent the spread of infectious			
	disease			
	B. Equipment			
	1. Soap			
	2. Water			
	3. Hand towel			
	4. Alcohol gel			
	D. Procedure			
	3. Decontaminate hands before and			
	after having direct contact with			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 31 of 43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/24/2012
	PROVIDER OR SUPPLIEI REHABILITATION A	R AND SKILLED NURSING CENTEI	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	donning gloves	ninate hands before (clean or sterile) *this nging of gloves in the rocedure"			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 32 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155697	B. WING		02/24/2012
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TALME OF I	NO VIDEN ON BOTTEIEN			LITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0356	483.30(e)				
SS=C	POSTED NURSI	E STAFFING			
	INFORMATION	post the following			
	information on a				
	o Facility name.				
	o The current da	te.			
		per and the actual hours			
		llowing categories of			
		icensed nursing staff directly esident care per shift:			
	- Registered	•			
- Licensed practical nurses or licensed vocational nurses (as defined under State law).					
	- Certified nu				
	o Resident censu	us.			
	The facility must	post the nurse staffing data			
		on a daily basis at the			
		h shift. Data must be posted			
	as follows:				
	o Clear and read				
	residents and vis	place readily accessible to			
	residents and vis	ntoro.			
	The facility must,	, upon oral or written request,			
		ing data available to the			
	•	at a cost not to exceed the			
	community stand	dard.			
	The facility must	maintain the posted daily			
	•	ta for a minimum of 18			
	months, or as red	quired by State law,			
	whichever is great	ater.			
	Based on observa	ation and interview, the	F0356	It is the practice of this provide	er to 03/25/2012
	facility failed to	ensure the daily nurse		ensure that nurse staffing	
	_	posted on February 21,		information is posted on a dail	.y
	_	he potential to affect all		basis.	
		ding in the facility and		What corrective action(s) wil	ı [
	their visitors.			be accomplished for those	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 33 of 43

	LTIPLE CONSTRUCTION (X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL	DING COMPLETED
155697 B. WING	02/24/2012
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE
Findings include: On entrance to the facility, on 2/21/12 at 8:40 a.m., the posted Daily Staffing was dated 2/17/12. The form was outside of the Administrative Offices. In interview with the Administrator at this time, he indicated it would be changed. 3.1-13(a)	residents found to have been affected by the alleged deficient practice? Staffing information was posted on 2/21/12. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken? All residents had the potential to be affected. Staffing information was posted on 2/21/12 for all residents and visitors to review. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur? On 2/21/12 Staffing Coordinator was re-educated by Executive Director on regulation regarding daily positing of staffing and appropriate form to use. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place. Executive Director will do random audits weekly for four weeks then monthly for six months to verify compliance. Audit results will be reported to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 34 of 43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00 	COMPI 02/24	LETED
NAME OF F	PROVIDER OR SUPPLIER	·	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		LITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
		,		CQI monthly.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 35 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155697	A. BUII			02/24/	2012
			B. WIN			02/2 !!	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
F0441	483.65					•	
SS=D	INFECTION CO	NTROL, PREVENT					
SPREAD, LINENS							
	•	establish and maintain an					
		Program designed to					
		anitary and comfortable					
		I to help prevent the					
	·	d transmission of disease					
	and infection.						
	(a) Infection Con	trol Program					
		establish an Infection					
	Control Program						
(1) Investigates, controls, and prevents infections in the facility;							
		t procedures, such as					
		be applied to an individual					
	resident; and						
	(3) Maintains a r	ecord of incidents and					
	corrective action	s related to infections.					
	(b) Preventing S	pread of Infection					
		ection Control Program					
	` '	a resident needs isolation to					
	prevent the spre	ad of infection, the facility					
	must isolate the	resident.					
	(2) The facility m	ust prohibit employees with a					
		isease or infected skin					
		ct contact with residents or					
		ct contact will transmit the					
	disease.						
		ust require staff to wash their direct resident contact for					
		ning is indicated by accepted					
	professional prac						
	professional prac	5.00.					
	(c) Linens						
	` '	handle, store, process and					
		so as to prevent the spread					
	of infection.	-					
	Based on record	review, observation and	F04	41	What corrective action(s) will	l	03/25/2012
		cility failed to maintain			be accomplished for those		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 36 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
		IDENTIFICATION NUMBER: 155697	A. BUILDING 00			COMPLETED 02/24/2012	
		100081	B. WIN	_	ADDRESS SITE STATE	02/24/2012	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY)		TE COMPLETION DATE	
1710		ction control related to		1710	residents found to have beer	_	
		or to care given on a			affected by the deficient		
		e (feeding tube) and a			practice?		
	"	rway tube). This affected			· Resident #50 has passed a	way	
	1 of 1 resident ob	oserved for G-tube and			How other residents having	the	
	tracheostomy car	re in a sample of 15.			potential to be affected by th		
	(Resident #50)				same deficient practice will be identified and what corrective		
					action(s) will be taken?	e	
	Findings include	d:			· All residents have the poter	ntial	
					to be affected by the alleged		
					deficient practice. Licensed Nursing staff will be	ne.	
		inical record for Resident			re-educated on tracheostomy		
		DNO(1)		gastrostomy care by the			
	indicated diagnos	ses including, but not	DNS/designee. Post test included.				
	limited to, status	post motor vehicle			· Licensed Nursing staff have	•	
	accident, tracheo	stomy (airway tube),			validation complete on tracheostomy and gastrostomy		
	gastrostomy tube	e (feeding tube) and			care on or before 3/25/12 by the		
	seizures.				Staff Development		
					Coordinator/designee. Non-compliance with these		
	On 2/22/2012 at	2:00 p.m., observation of			practices will result in further		
	care given to Res	sident #50 was watched.			education including disciplinar	у	
	Registered Nurse	e #1 (RN) entered the			action. Director of nursing		
	room and explain	ned to resident what she			services/designee is responsil	ole	
	was going to do,	and she then proceeded			to ensure compliance.		
	with setting up ed	quipment for flushing the					
	gastrostomy tube (G-tube) and checking				What measures will be put in	ito	
	placement.				place or what systemic changes will be made to		
	RN #1 put the tul	be feedings on hold and			ensure that the deficient		
	_	oam cups, each with 120			practice does not recur?		
		put gloves on and placed			 Licensed Nursing staff has been re-educated on 		
		bdomen and checked			tracheostomy, gastrostomy ca	re	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		155697	B. WIN			02/24/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER				517 N LITTLE LEAGUE BLVD			
CLARK F	REHABILITATION	AND SKILLED NURSING CENTER	2		SVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
	1 *	g a 30 cc air bolus.			and hand washing by the DNS/designee. Post test		
		d the stethoscope and			included.		
	1	back on and then cleaned			 Licensed Nursing staff will the checked off on tracheostomy and tracheostomy and the checked off. 		
	up G-tube suppl	lies and removed gloves.			gastrostomy care on or before		
	RN # 1 proceed	ed to put a new set of			3/25/12 by the Staff Developm		
	gloves on and se	et up for tracheostomy			Coordinator/designee. Non-compliance with these		
	care.				practices will result in further		
	RN # 1 removed	d oxygen and removed old			education including disciplinar	у	
	dressing from a	round outer trachea and			action.		
	then removed in	ner cannula and removed			How the corrective action(s)		
	gloves.				will be monitored to ensure t		
	RN # 1 applied	sterile gloves and poured			deficient practice will not rec i.e., what quality assurance	;ur,	
	hydrogen perox	ide into container and			program will be put into plac	:e?	
	proceeded to we	et a cotton applicator with			· The CQI skills check off for		
	solution and wij	ped inside trachea.			tracheostomy and gastrostomy	у	
	RN # 1 wet a new cotton applicator and				care will be utilized weekly x 4 bi-weekly x 2 months, monthly		
	wiped around th	ne outside of the outer			and quarterly thereafter.	***	
	trachea and on I	Resident #50's skin and			· Findings from the CQI proc		
	then inside track	nea with same cotton			will be reviewed monthly and a action plan will be implemente		
	applicator.				for thresholds below 95%.		
	RN # 1 took off	sterile gloves and opened					
	normal saline (N	NS) and put on non-sterile					
	gloves and proc	eeded with rinsing off the					
	trach.						
	RN # 1 took a 4	x4 pad and wet it with the					
	NS and wiped in	nside the trachea and then					
	got a new 4x4 pad and wet it with the NS						
	and wiped arou	nd outside and on					
	resident's skin.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 38 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPLETED	
		155697	B. WIN			02/24/2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	
CLARK REHABILITATION AND SKILLED NURSING CENTER		₹		SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
1710		be cleaner and dried		mo		DATE
		a and used a new pipe				
		ed around outside and on				
	_	n. RN #1 put a new trach				
		tened, and then removed				
	gloves and wash	ed nands.				
	On 2/22/2012 at	4:00 p.m., in an				
	interview with th	ne Corporate RN #2, she				
	indicated she wo	ould expect that nursing				
	would wash their	r hands before and after				
	G-tube care and	trachea care.				
	On 2/24/2012 at	1:40 p.m., review of the				
		WASHING POLICY				
	AND PROCEDU	JRE," provided by				
		indicated, but was not				
	limited to:					
	"A. Purpose					
	1. To preven	at the spread of infectious				
	disease					
	B. Equipment					
	1. Soap					
	2. Water					
	3. Hand tow	el				
	4. Alcohol g	el				
	D. Procedure					
		ninate hands before and				
	after having dire					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 39 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155697	A. BUILDING 00 COMPLETED 02/24/2012				
		155697	B. WIN			02/24/	2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
CLARK REHABILITATION AND SKILLED NURSING CENTER			!		ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	patients	inate hands before					
		clean or sterile) *this					
		nging of gloves in the					
	middle of any pr	ocedure"					
	On 2/24/2012 at	2:40 p.m., review of RN					
	#1's General Orio	• '					
		ent Form dated 8/5/2011,					
	indicated, but wa						
	· ·	Masking, Gloving,					
		C .					
	Gowning Techni	-					
	PrecautionsInfo						
		These were signed off as					
	being completed						
	3.1-18(j)						
	3.1-18(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet Page 40 of 43

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DUILDING 00			COMPLETED	
155697		A. BUILDING 02/24				2012	
			B. WIN		ADDRESS SITE STATE THE CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
OLARIZ RELIABILITATION AND OWN ER MURONIO OFFITER			517 N LITTLE LEAGUE BLVD				
CLARK R	CLARK REHABILITATION AND SKILLED NURSING CENTER			CLAR	KSVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0456	483.70(c)(2)						
SS=E		UIPMENT, SAFE					
	OPERATING CO						
	•	maintain all essential					
		trical, and patient care					
		e operating condition.					
	Based on record	review, interview and	F04	56	What corrective action(s) wil	1	03/25/2012
	observation, the	facility failed to ensure			be accomplished for those		
	•	and Up lift batteries were			residents found to have been		
	•	g to manufacturer's			affected by the alleged		
	-				deficient practice?		
	instructions, for 3	-			The beautiff and stand on	i.tr	
		leficient practice had the			The hoyer lift and stand-up batteries are charged per	ΙΙΤ	
	potential to affect	t 15 residents who utilize			manufacturer's instructions.		
	the Hoyer/Stand	Up lifts.			manulaciulei s ilistructions.		
					How will you identify other		
	Findings include				residents having the potentia	al	
	i mamga merade	•			to be affected by the same		
	0. 02/20/12 1				alleged deficient practice and	d	
		ing the confidential group			what corrective action will be		
		13 residents (#100 and			taken?		
	#101) indicated t	hat the Hoyer and Stand			· Residents transferred with a	a	
	Up lifts did not a	lways function as the			hoyer or stand-up lift have the		
	batteries were lo	W.			potential to be affected by the		
					alleged deficient practice.		
	On 02/23/12 at 9	:22 a.m., two Hoyer and			· Nursing staff have been		
		•			in-serviced on charg		
	•	fts were observed stored			 ing the hoyer/stand-up lift batteries by the DNS/designed 	o on	
		n. One had a sign			2/24/12. Post test included.	5 011	
	indicating it was	out of order. The battery			Extra batteries and chargers	s	
	on both Stand Up	Lifts failed to operate			have been ordered to ensure	-	
	the equipment wi	hen the controls were			availability of fully charged		
		‡1 (Licensed Practical			batteries for use.		
	Nurse).	. 1 (2.0011000 1.10011001			· A log sheet has been initiate	ed	
	ivuise).				so as when a battery is placed	l on	
					a charger it is charged for at le		
	LPN #1 obtained	a battery from the			6 hours per the manufacturer's	S	
	charging station	and placed it in the lift.			instructions.		
	The battery lacke	ed enough charge to			• The c.n.a. will charge the ho	oyer	
			l		batteries at all times and the		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/24/2012			
	PROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	in place to ensur charged, LPN # Nursing Assistar battery on the ch system was in pro- were left in the ch charged.	his time what system was re the batteries were I indicated the Certified nts would place the narger for recharging. No lace to ensure the batteries charger until fully e Director provided the		maintenance department will check the batteries to ensure the are charged and properly functioning each morning. Non-compliance with these practices will result in further education including disciplinar action. DNS/designee to monitor for compliance.	y or
	manufacturer's i 02/23/12 at 10:4 this time, the ins batteries needed hours. At this ti	nstructions for the lifts on 0 a.m. Upon review at structions indicated the to be charged for 4 to 6 me, the Maintenance ed he was ordering extra		place or what systemic changes you will make to ensure that the alleged deficient practice does not recur? Nursing staff have been in-serviced on charging the hoyer/stand-up lift batteries by DNS/designee on (date). Postest included. Extra batteries and charged have been purchased to ensure availability of fully charged batteries for use. A log sheet has been initiate so as when a battery is placed a charger it is charged for at left hours per the manufacturer's instructions. The c.n.a. will charge the hobatteries at all times and the maintenance department will or random weekly checks to ensure charged and properly functioning. Non-compliance with these practices will result in further education including disciplinar action.	ed lon east s

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 42 of 43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012 FORM APPROVED OMB NO. 0938-0391

S X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/24/2012
	STREET A 517 N L	ITTLE LEAGUE BLVD	DE
CIENCY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY) DNS/designee to more	ULD BE COMPLETION DATE
		compliance.	
		How the corrective activill be monitored to endeficient practice will ni.e., what quality assurate program will be put into. The maintenance supervisor/designee will hoyer lift battery tool to elebatteries are charged daweeks, bi-weekly x 3 modular quarterly x 3 thereafter. Findings from the CQ will be reviewed monthly action plan will be impler for thresholds below 95%	sure the ot recur, ance o place? utilize the ensure illy x 4 inths and I process and an mented
) H	IDENTIFICATION NUMBER: 155697 PLIER	IDENTIFICATION NUMBER: 155697 A. BUILDING B. WING PLIER ON AND SKILLED NURSING CENTER CLARK RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PERCEDED BY FULL PREFIX	DENTIFICATION NUMBER: 155697 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COL 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129 RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PERCEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) DNS/designee to mor compliance. How the corrective acti will be monitored to en- deficient practice will in i.e., what quality assura program will be put into The maintenance supervisor/designee will hoyer lift battery tool to e batteries are charged da weeks, bi-weekly x 3 mor quarterly x 3 thereafter. Findings from the CQ will be reviewed monthly action plan will be implei

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U69E11

Facility ID: 000059

If continuation sheet

Page 43 of 43